VETERANS NEWS & VIEWS – JANUARY, 2010

Left to right Barbara Gescheidle, Norm Arnswald, President of Veterans Assistance Commission of Lake County and Thomas Gescheidle

Barb and Tom Gescheidle, from Smokin T's of Long Grove, receive a certificate of appreciation from the V.A.C. for delivery of 70 meals for Christmas and Thanksgiving Dinners which fed 700 veterans and their family members in Lake County

THANK YOU SMOKIN T'S

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VAC ANNUAL CHRISTMAS BRUNCH AND VOLUNTEER PARTY

Johnnie L Allen Awards
Prseented to:
Zion Benton American Legion Post 865 - 3,452 hours
Winthrop Harbor VFW Post 7448 – 3,334 hours
Lake Zurich American Legion Post 964 – 3,255 hours
Lake County Marine Corps Leagues #801 – 2,693 hours
Mundelein American Legion Post 867 – 2,691.5 hours

Volunteer Service Award Presented to the following
Back Row
Left to right:
Bob Sittler, Gold Pin, Dick Kutz, Gold Pin, Richard Johnson,Silver Pin, Tom Marciciak, Gold Pin, Bob Perosa, Gold Pin, B J Voit, Bronze Pin, Louis Rodriguez, Bronce Pin, John Van Geem, Norm Arnswald, Bronze Pin, Nick Konz, Silver Pin, Jerry Vleck, Gold Pin, Lizabeth Risely, Bronze Pin, Mary Jane Lucas, Gold Pin, John Shebenik, Silver Pin

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Superintendents Report – January, 2009

By Michael P. Peck

I can't say enough about the volunteer efforts of Lake County Veterans. Our total hours reported for all Veteran Service Organizations totaled over 96,000 hours. This shows how veterans care for veterans.

I must again thank Tom and Barbara Gescheidle of Smokin T's Restaurant as they prepared over 70 meals that fed 700 veterans and their families on Thanksgiving and Christmas. The meals were delivered to their homes and for many, this was the first family holiday meal in which they were able to invite extended family members to their own home.

The work of Catholic Charities and the Marine Corps Reserve Toys for Tots program provided Christmas gifts for our 115 veterans families who are on food stamps.

As we enter the new year we are excited that we have received official notification of our $50,000 dental grant from the Health Care Foundation of Lake County. This grant will allow us to continue our dental care program which provided assistance to 90 veterans who needed dental care in 2009. We are submitting a second grant to the IDVA which provides funding from the Veterans Scratch off lottery ticket sales.

We are also very active with the Community Action Partnership which is helping to provide a food voucher supplement for those veterans on food stamps. We used to call this the soap and paper account as it would allow the purchase of toiletries, laundry and clean supplies and paper goods such as paper towels and toilet paper that could not be purchased with food stamps. The grant is limited to $13,000 but every dollar helps.

One of our least known programs is the assistance with the burial of veterans and their dependents. Last year the County Board designated the Superintendent as the responsible party to insure the burial of indigent veterans. This action was needed to insure that military honors and burial of the veteran in a national cemetery were provided. A veteran who served his county should be accorded these honors and not placed in a paupers grave.

Our remote access to the VBA Regional Office and the work with the VBA office at North Chicago has insured that no claims processed by this office are lost in the mail and that all claims are received in a timely manner. Last year we processed 2,313 claims, an increase of 200 claims over 2008. Compensation and pension dollars for Lake County Veterans rose from $35 million to $40 million while our veteran population dropped from 43,000 to 42,000.

The American Legion and VFW provided an outstanding Christmas Program at North Chicago VAMC and we were able to include the veterans at Winchester House in this years program.

We will again schedule another Stand Down in October, 2010. This year, along with the grant from the Department of Labor and help from the Vernon Hills Police Department, we provided over 140 new winter coats. With the help from Zengeler Cleaners of Libertyville we were able to assist the families of many veterans with clothing for their spouses and their children.

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Our outreach program continues, and I urge all post's to invite us in for a day where we can process claims at your post's home. Mark your calendar now for our Lake County Veterans Service Officer Seminar on Saturday, October 16th. The Lake Zurich American Legion Post will once again be our host and provide an outstanding lunch.

Again, a thank you to all the Veterans Service Organizations and their auxiliaries in Lake County who made our efforts in 2009 possible. We could not provide the help to veterans without you.

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IMPORTANT DATES -- 2010

New Year's Day	January 1, 2010
Stakeholders Meeting, NCVAMC Bldg 134	January 11, 2010
Martin Luther King Jr Birthday	January 18, 2010
VAC Meeting – NCVAMC, Bldg 135	January 20, 2010
Stakeholders Meeting NCVAMC Bldg 134	February 8, 2010
Lincoln's Birthday	February 12, 2010
VAC Meeting – NCVAMC, Bldg 135	February 17, 2010
Stakeholders Meeting NCVAMC Bldg 134	March 8, 2010
VAC Meeting – NCVAMC, Bldg 135	March 17, 2010
Good Friday	April 2, 2010
Easter Sunday	April 4, 2010
Stakeholders Meeting NCVAMC Bldg 134	April 12, 2010
VAC Meeting – NCVAMC, Bldg 135	April 21, 2010
Stakeholders Meeting NCVAMC Bldg 134	May 10. 2010
VAC Meeting – NCVAMC, Bldg 135	May 19, 2010
Memorial Day	May 31, 2010
Stakeholders Meeting NCVAMC Bldg 134	June 14, 2010
Independence Day	July 4, 2010
Stakeholders Meeting NCVAMC Bldg 134	July 12, 2010
Stakeholders Meeting NCVAMC Bldg 134	August 9, 2010
Labor Day	September 6, 2010
Stakeholders Meeting NCVAMC Bldg 134	September 13, 2010
VAC Meeting – NCVAMC, Bldg 135	September 15, 2010
Columbus Day	October 11, 2010
Veteran Service Officer Training – Lake Zurich	October 16, 2010
Stakeholders Meeting, NCVAMC Bldg 134	October 18, 2010
Standown, VAC Office	October 19, 2010
VAC Meeting – NCVAMC, Bldg 135	October 20, 2010
Election Day	November 2, 2010
Stakeholders Meeting NCVAMC Bldg 134	November 8, 2010
Veterans Day	November 11, 2010
VAC Meeting – NCVAMC, Bldg 135	November 17, 2010
Thanksgiving Day	November 25, 2010
Stakeholders Meeting NCVAMC Bldg 134	December 13, 2010
Christmas Day	December 25, 2010

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Health Care Reform Update 20:

As you are most probably aware of by now, on the morning of 4 DEC, the Senate passed 60-39 a much amended H.R.3590, "The Patient Protection and Affordable Care Act. This vote and the previous House passage of this legislation is contrary with the growing sentiments of 2/3 of the American People who are against this "stealth" legislation. Regardless of which national poll you might consider this public disapproval of this legislation varies little from poll to poll. As the next step in the process is reconciliation of the significantly different House and Senate versions, but which neither makes provision to protect Veterans Affairs and Department of Defense health-care from the provisions of this legislation. Such protection would fulfill President Obama's promise made last August that neither program would "be affected by our efforts at broader health-care reform." Unless Tricare, Tricare for Life, and VA health care programs are exempted from a proposed excise tax, veterans and military retirees face the very real prospect of paying a new tax on so-called "Cadillac" health care plans, which Tricare and VA health-care might easily be considered. As has been pointed out by a number of federal employee labor unions, such a tax would "have a discriminatory impact on plans that cover older workers and retirees ..." Such excise tax could result in a tax increase of as much as 1.4% on veterans and military retirees and our widows, many of whom are retired on fixed incomes with no way to offset that additional tax other than by cutting back elsewhere in their family budgets.

If you could be impacted by this you have the option to contact your legislator and let him/her know of your concerns. Especially the very real potential that the near $500 Billion cuts in Medicare will adversely impact Tricare and Tricare for Life which are directly indexed to Medicare. If Medicare goes away then so do Tricare and Tricare for Life. Urge your legislator to immediately seek an amendment to H.R.3590 to make it clear that nothing in the reconciled bill act shall interfere with VA or DOD existing authorities and that VA and DOD health care programs are excluded from any excise tax on health care programs. If H.R.3950 is not so amended then request that he/she vote AGAINST this legislation when it comes to the House floor for a vote. To facilitate contacting your legislator USDR has provided an editable message at http://capwiz.com/usdr/issues/alert/?alertid=14493596&queueid=[capwiz:queue_id] that addresses the issue and can be automatically forwarded to your representative. [Source: USDR Action Alert 26 Dec 09 ++]

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Life Expectancy:

Life expectancy is up and the death rate is down, according to recent data from the U.S. Centers for Disease Control and Prevention (CDC). From data collected in 2007, life expectancy for newborns reached a new high of 77.9, according to the latest mortality figures reported in Deaths: Preliminary Data for 2007. The figures are based on nearly 90% of all death certificates in the United States. The 2007

increase in life expectancy was the continuation of a long trend. Between 1997 and 2007, life expectancy increased by 1.4 years, from 76.5 years to 77.9 years. Other highlights of the report include:

- The average 65-year-old senior can now expect to live another 19 years or so, to nearly age 84.
- Record high life expectancy was recorded for both males (75.3 years) and females (80.4 years) in 2007. While the gap between male and female life expectancy has narrowed since the peak of in 1979, the 5.1 year difference recorded in 2007 is the same as in 2006.
- For the first time, life expectancy for black males reached 70 years.
- The U.S. death rate fell for the eighth year in a row to an all-time low of 760.3 deaths per 100,000 population in 2007. This is 2.1% lower than the 2006 rate of 776.5 and about half of what it was 60 years ago in 1947.
- Heart disease and cancer, the two leading causes of death, accounted for nearly half (48.5 percent) of all deaths in 2007.

Want to improve your longevity? In addition to getting exercise, regular medical checkups, and eating healthy food, researchers say that making time to travel and making new friends help to increase our longevity. Travel can increase longevity by helping people establish and maintain a healthy lifestyle, says Dr. David Lipschitz, director of the Center on Aging at the University of Arkansas for Medical Sciences. In a 10-year longevity study of people aged 70 and older, researchers at the Centre for Ageing Studies at Flinders University in Adelaide, Australia concluded:

- Close relationships with children and relatives had little effect on longevity rates for older people during the 10-year study.
- People with extensive networks of good friends and confidantes outlived those with the fewest friends by 22%.
- The positive effects of friendships on longevity continued throughout the decade, regardless of other profound life changes such as the death of a spouse or other close family members.

[Source: About.com Guide to Senior Living Sharon O'Brien article 26 Dec 09 ++]

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Estate Tax Update 03 (U.S.):

Unless Congress changes the law, the federal estate tax will disappear on 1 JAN 2010. For the first time since the 1916 inception of the tax, the estate of anyone dying in 2010 will go to heirs tax free, a result of the 2001 tax law that phased out the estate tax over 10 years. But that law itself expires in 2011 and the estate tax will revert to pre-2001 law. The Economic Growth and Tax Relief Reconciliation Act of 2001 increased the effective estate tax exemption in steps from $675,000 in 2001 to $3.5 million in 2009 and reduced the top tax rate from 55% to 45%. Raising the exemption cut the share of estates subject to tax by nearly 90% — from 2.14% in 2001 to a projected 0.23% in 2009. That percentage is the lowest since at least 1934. With the 2009 exemption of $3.5 million, an estimated 5,500 estates will pay the estate tax, yielding revenue totaling nearly $14 billion. Revenues will drop to zero in 2010 (but a sharp increase in gift tax collections will make up some of the loss, albeit at the cost of lower estate taxes in future years). If the estate tax reverts to pre-2001 law and its $1 million exemption, an estimated 44,000 estates — representing just under 2% of all deaths — will owe tax totaling more than $34 billion.

Congress is currently debating various options to change the estate tax in 2010 and subsequent years. One approach would make the 2009 parameters permanent, thus imposing the tax on about one-quarter of 1 percent of estates in 2010. That share would grow slowly over time if the $3.5 million exemption were not indexed for inflation, rising to about 0.4% by 2019. Revenues would roughly double over the decade from $14.8 billion in 2010 to $28.9 billion in 2019. Indexing the exemption would slow but not halt that growth as wealth will likely increase faster than prices. Other proposals in Congress would increase the exemption to $5 million and reduce the tax rate to 35%, either immediately or by 2019. The higher exemption would cut the number of estates subject to tax and, in combination with the lower tax rate, would slash revenues by nearly half. The Tax Policy Center has projected the effects of those and other proposals at www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2506.Estate. [Source: Tax Policy Center Tax Facts Roberton Williams article 21 Dec 09 ++]

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DoD Vet Betrayal Update 01:

Veterans groups hailed the passage of the 2008 National Defense Authorization Act (NDAA), which made it easier for wounded soldiers to have their injuries rated and treated by the federal government. But less than a year after President Bush signed the bill, the Defense Department interpreted the law in a way that reduced its scope and denied many veterans the benefits they thought they had been promised. The Pentagon's interpretation, which veterans groups are challenging, is laid out in two memos written in 2008 by David S.C. Chu, who was undersecretary of defense for personnel and readiness. The effect of the memos, which have been obtained by The Washington Times, is to disqualify numerous soldiers who suffer from post-traumatic stress disorder (PTSD) from receiving medical benefits and to prevent others from receiving extra pay that the NDAA promised to veterans with combat-related injuries. In drafting the NDAA, Congress relied on the recommendations of a bipartisan panel headed by former Senate Majority Leader Bob Dole and former Health and Human Services Secretary Donna E. Shalala. The legislation permitted troops who were injured during training operations to receive extra pay, but Mr. Chu, in one of his memos, defined "combat-related operations" in such a way that troops injured during training or simulated conditions of war would not qualify.

Some lawmakers involved in enacting the 2008 law had expected differently. During debate on the Senate floor, Sen. Mark Pryor (D-AR) said: "This addition expands the population that is eligible for the enhancement of disability severance pay to include injuries incurred during performance of duty in support of combat operations." But Congress did not explicitly include in the bill a definition of combat-related operations, leaving it to the Pentagon to make that determination. The result was Mr. Chu's first memo, issued in MAR 08. Mr. Chu said that the injury must have been inflicted during "armed conflict," or in a combat zone, in order for the service member to receive the benefits authorized. "The fact that a

member may have incurred a disability during a period of war or in an area of armed conflict, or while participating in combat operations is not sufficient to support this finding [of a combat-related disability]. There must be a definite causal relationship between the armed conflict and the resulting unfitting disability," Mr. Chu wrote in a document attached to his MAR 08 memo. This excluded soldiers who were hurt while engaging in operations outside combat zones, including situations Mr. Pryor envisioned: conducting training exercises, jumping from helicopters in rough terrain or participating in other hazardous duties.

Officials maintain that the scope of the law was narrowed to ensure that combat-wounded soldiers would receive the bulk of the new benefits. Many veterans groups view it as an unwelcome cost-saving measure. David Gorman, executive director of the Disabled American Veterans, wrote a letter to every member of Congress in AUG 08 that said: "Sadly, the 2007 Walter Reed scandal, which resulted mostly from poor oversight and inadequate leadership, pales in comparison to what we view as deliberate manipulation of the law" by Mr. Chu and his deputies. "He must not be allowed to continue thumbing his nose at the will of Congress and the American people," Mr. Gorman said. Mr. Chu, who is no longer with the Defense Department, told The Times that an "enormous amount of confusion" has been associated with the memo and advised The Times to speak with William Carr, the acting deputy undersecretary for military personnel policy. The Department of Defense did not make Mr. Carr available for an interview and instead issued a statement through Pentagon spokeswoman Cynthia O. Smith, who confirmed that the MAR 08 memo was still in effect.

The 2008 NDAA also made it easier for soldiers dismissed from service because of PTSD to undergo treatment and receive compensation. The law said veterans dismissed from service because of PTSD must be given a disability rating of 50%, high enough to ensure disability pay and health care for the soldiers and their families. But another memo written by Mr. Chu on 14 OCT 08, added a catch: It said the policy should not go into effect until the date of the memo, nine months after the bill had been signed into law, leaving out any soldiers dismissed from service because of PTSD before that date. Many soldiers with PTSD who were dismissed from service before the October deadline suffered severe physical injuries as well. They included long-serving, decorated soldiers regularly exposed to mortar fire and roadside bombs. Seven of them have banded together with the National Veterans Legal Services Program in a class-action lawsuit, filed in DEC 08, seeking the 50% rating. Bart Stichman, a lawyer handling the case for the veterans legal services program, said the military has a "history of lowballing" the ratings and estimates that there are "thousands who have been discharged before OCT 08 that the military has done nothing about."

One of the soldiers suing is former Army Sgt. Juan Perez, who was discharged from the military in 2006 after being deemed unfit for further service because of a PTSD diagnosis. During his first deployment to Iraq, he routinely carried out reconnaissance missions near the Syrian border. On one occasion, his Bradley fighting vehicle was hit with an improvised explosive device. But it was during his second deployment when he sustained an injury, as an industrial-strength bungee cord restraining

ammunition lost its hold and snapped violently against his head. The injury caused him to temporarily lose his eyesight, and he was flown to Germany for treatment. He then began suffering migraines and sometimes losing consciousness. He was sent later to the United States, where he began to experience PTSD symptoms, including insomnia, paranoia and extreme irritability. He was later diagnosed with PTSD and traumatic brain injury. Because of the PTSD diagnosis, the Army officially declared him no longer fit to serve and dismissed him from duty in 2006, before any of the 2008 NDAA benefits became available. Perez said, "They didn't include my eye injury. They just said I was unfit to be a soldier anymore. And they gave me 0 percent for PTSD. They gave me a severance package, but that didn't even last three months. If I would have gotten a 30% rating, at least, I could have medical care for my wife and kids, but now I don't have that." Sgt. Perez says he can see, but not as well as before the accident. He suffers from migraines and carries an oxygen tank to help alleviate the headaches. [Source: The Washington Times Amanda Carpenter article 28 Dec 09 ++]

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TRDP Update 08:

Tooth loss can be a difficult and sometimes embarrassing condition. Quality of life, confidence or daily functioning can be affected by the loss of permanent teeth. Tricare wants beneficiaries to know that conventional crown and bridge treatment and dentures aren't the only options to address tooth loss. Dental implants are an option for medically qualified candidates. A thorough dental evaluation is required to determine whether a patient is a good candidate for dental implants. Good candidates for a dental implant are non-smokers with healthy gums and adequate bone remaining in the area where the implant will be placed. A dental implant is a replacement for the root portion of a natural tooth and is surgically placed in the upper or lower jaw, below the gum line. After a healing period, the implant supports a crown or bridge, or secures a denture firmly in place. Beneficiaries considering dental implants should speak with their dentist about the total cost of the procedure to determine their out-of-pocket expenses. On average, dental implants cost approximately $1,500 to $3,500 per tooth replacement. Beneficiaries should plan ahead to properly budget their annual dental benefit. To learn more about Tricare's dental benefits refer to http://www.tricare.mil/dental. [Source: Tricare News Release 09-81 24 Dec 09 ++]

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VA Blue Water Claims Update 09:

The VA is currently building their list of Blue Water Navy ships (which include Coast Guard vessels) that performed duties on inland waterways. The Washington office at VA Headquarters is spearheading this effort and they have notified all the Regional Offices that whenever they get information regarding Blue Water Navy ships that sailed on inland waters and/or BWN ships that docked in Vietnamese ports or

harbors, they are to submit that information to the DC offices for verification. Information from Deck Logs and other sources will be investigated for credibility. In filing a claim based on presumptive exposure to herbicides if your ship was in port or on inland waters, the best thing you can do is present the Regional Office (RO) along with your claim submission certified copies of the information you are using to prove this situation. In many cases, information from a Cruise Book is ideal. Information from your ship's history from Internet sites is also good. Send a copy of that portion of the Cruise book, ship's history and/or photos that show river service or docking, along with a request for the Regional VA Office to obtain the deck logs for that time period to substantiate your claim. Statements attesting to the fact that what you are submitting is true to the best of your knowledge should also be sent. You should have a VSO or the RO itself certify that the copies being submitted are true copies of the original documents which you need to show, but retain in your possession. The ROs will submit the certified copies of this information to the Comp & Pen Division in Washington, and the database of these inland water services will be created after verification of this information. The ultimate goal of this will be a database searchable by the Regional Offices that will validate your claims for presumptive exposure if the ship, for your specified timeframe, is in the database already from someone else's claim. Otherwise, your submission will create the first entry into the database. You will not have to bear the cost of obtaining the Deck Logs under this scenario. That will be the responsibility of the VA. Include a copy of the 19 OCT 09 letter from Secretary Shinseki to Senator Akaka which mentions the development of this searchable database of BWN ships serving in Vietnam. To download a copy of that letter refer to www.bluewaternavy.org/10-19-09-VA-Shinseki-response.pdf. [Source: www.bluewaternavy.org/newspage2.htm Dec 09 ++]

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Celiac Disease:

This digestive disorder causes damage to the small intestine when gluten, a protein found in wheat, barley and rye, is ingested. People with the disease need to follow a strict gluten-free diet for the rest of their lives to avoid serious complications like osteoporosis and lymphoma, an immune system cancer. It takes the average patient 10 years to receive a diagnosis. And according to specialists, they are the lucky ones. Studies show that 3 million Americans or 1 in every 133 people have celiac disease. But 95% of them have yet to learn they have it, according to the National Institutes of Health. "The entire disease and all of its manifestations are incredibly under diagnosed," said Dr. Charles Bongiorno, the chief of the division of gastroenterology and hepatology at the University of Medicine and Dentistry of New Jersey. "Patients often have it for a decade or two before they are diagnosed." Celiac disease is often difficult to detect because the symptoms vary so widely from person to person. Ten years ago, the medical community thought it was a rare disorder that affected only 1 in every 10,000 people, primarily children who had digestive problems and failure to thrive.

Physicians now know that the disease is much more common. Most patients never experience the so-called classic symptoms: bloating, chronic diarrhea and stomach upset. Instead, the signs are often as nebulous as anemia, infertility and osteoporosis. "It's a problem," said Dr. Ritu Verma, section chief of gastroenterology, hepatology and nutrition and director of the Children's Celiac Center at the Children's Hospital of Philadelphia. "The majority of patients do not have the traditional signs and symptoms. If someone's only presenting symptom is anemia, physicians will think of a hundred other things before they think of celiac disease." As a result, the condition is also commonly mistaken for other ailments. Part of the problem is also a lack of education among physicians, particularly internists. According to Dr. Bongiorno, most primary care physicians are simply unaware of new research that shows the disease is common and can manifest itself in unusual ways. "They think it is an exotic malady," he explained. "That persistent fallacy causes a less-than-appropriate effort to order the right blood tests and refer to gastroenterologists for care."

In 2006, the National Institutes of Health started a campaign to raise awareness of the disease among both the general public and physicians. A goal was to increase rates of diagnosis because, unlike many ailments, there is a definitive way to stop celiac disease from progressing once it is recognized. "The vast majority of cases experience a complete remission from symptoms once they are diagnosed and go on a gluten-free diet," said Dr. Stefano Guandalini, director of the University of Chicago Celiac Disease Center. "So essentially, you have no disease. That is what makes it all the more important to be diagnosed." And there is no better time to be on a gluten-free diet. In 2008, 832 gluten-free products entered the market, nearly 6 times the number that debuted in 2003. Last year gluten-free even emerged as a fad diet in the general population. Dr. Fasano said gluten-free products used to taste like cardboard but had significantly improved in recent years. "The only problem," he said, "is that they cost five or six times more than their normal counterparts." Researchers are also beginning to experiment with drugs that may be able to block the immune response to gluten, much like a lactate pill. If the clinical trials are successful, individuals with celiac disease may be someday able to ingest small amounts of gluten. [Source: New York Times Health Guide 22 Dec 09 ++]

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Agent Orange Record of Neglect Update 01:

Documents show that decisions by the U.S. military and chemical companies that manufactured the defoliants used in Vietnam made the spraying more dangerous than it had to be. As the U.S. military aggressively ratcheted up its spraying of Agent Orange over South Vietnam in 1965, the government and the chemical companies that produced the defoliant knew it posed health risks to soldiers and others who were exposed. That year, a Dow Chemical Company memo called a contaminant in Agent Orange "one of the most toxic materials known causing not only skin lesions, but also liver damage." Yet despite the mounting evidence of the chemical's health threat a review of court documents and records from the National Archives has found the risks of exposure were downplayed and the spraying campaign would

continue for six more years. Records also show that much of the controversy surrounding the herbicides might have been avoided if manufacturers had used available techniques to lessen dioxin contamination and if the military had kept better tabs on levels of the toxin in the compounds. Dow Chemical knew as early as 1957 about a technique that could eliminate dioxin from the defoliants by slowing the manufacturing process, according to documents unearthed by veterans' attorneys. Since the Vietnam War, dioxin has been found to be a carcinogen associated with Parkinson's disease, birth defects and dozens of other health issues. Thousands of veterans as well as Vietnamese civilians were directly exposed to the herbicides used by the military. Debilitating illnesses linked to defoliants used in South Vietnam now cost the federal government billions of dollars annually and have contributed to a dramatic increase in disability payments to veterans since 2003.

Documents show that before the herbicide program was launched in 1961, the Department of Defense had cut funding and personnel to develop defoliants for nonlethal purposes. Instead it relied heavily on the technical guidance of chemical companies, which were under pressure to increase production to meet the military's needs. The use of defoliants led to massive class-action lawsuits brought by veterans and Vietnamese citizens against the chemical firms. The companies settled with U.S. veterans in the first of those suits in 1984 for $180 million. Since then, the chemical companies have successfully argued they are immune from legal action under laws protecting government contractors. The courts also found that the military was aware of the dioxin contamination but used the defoliants anyway because the chemicals helped protect U.S. soldiers. A 1990 report for the secretary of the U.S. Department of Veterans Affairs found that the military knew that Agent Orange was harmful to personnel but took few precautions to limit exposure. The report quotes a 1988 letter from James Clary, a former scientist with the Chemical Weapons Branch of the Air Force Armament Development Laboratory, to then- Sen. Tom Daschle, who was pushing legislation to aid veterans with herbicide-related illnesses. "When we initiated the herbicide program in 1960s, we were aware of the potential for damage due to dioxin contamination in the herbicides," Clary wrote. "We were even aware that the 'military' formulation had a higher dioxin concentration than the 'civilian' version due to the lower cost and speed of manufacture. However, because the material was to be used on the 'enemy,' none of us were overly concerned."

Military scientists had been experimenting with herbicides since the 1940s, but funding cuts in 1958 left few resources in place to fully evaluate the chemicals for use in Vietnam. "I was given approximately 10 days notice to come to Vietnam to undertake 'research' in connection with the above tasks," wrote Col. James Brown of the U.S. Chemical Corps Research and Development Command in an October 1961 report to top brass just as the defoliation program was ramping up. "Thus, a large order was placed on a very poorly supported research effort." The military launched a limited herbicide program in 1962 that involved 47 missions. At the time, relatively little was known about the health effects of dioxin, in part because cancer and other illnesses can take decades to develop and the herbicides had only been in wide use since 1947. But documents uncovered by veterans' attorneys show the chemical companies knew that ingredients in Agent Orange and other defoliants could be harmful. As early as 1955, records show, the German chemical company Boehringer had begun contacting Dow about chloracne and liver problems at

a Boehringer plant that made 2,4,5-T, the ingredient in Agent Orange and other defoliants that was contaminated with dioxin. Unlike U.S. chemical companies, Boehringer halted production and dismantled parts of its factory after it discovered workers were getting sick.

The company studied the problem for nearly three years before resuming production of 2,4,5-T. In doing so, the company found that dioxin was the culprit and that they could limit contamination by cooking the chemicals at lower temperatures, which would slow production. Dow said it didn't purchase the proprietary information on the technique until 1964 and didn't start using it until 1965. Records show it did not inform other manufacturers or the government about the technique until the military began planning construction of its own chemical plant to make herbicides in 1967. By that time, Dow also had developed a procedure to test dioxin levels in batches of 2,4,5-T. The company provided that technique to other companies in 1965 but not to the military until 1967, the company said. Earlier in the decade, nearly two dozen military officials and chemical industry scientists met in April 1963 to issue a "general statement" about the health hazards from 2,4-D and 2,4,5-T. No one raised concerns about using the chemicals in Vietnam, according to minutes from the meeting. Evidence focused largely on the fact that more than 300 million gallons of the compounds had been used domestically since 1947, even though the formulations for Vietnam would be far more concentrated and contain more dioxin. "The committee concluded that no health hazard is or was involved to man or domestic animals from the amounts or manner these materials were used in aforementioned exercise," the minutes show.

In 1965, the chemical companies involved in producing the defoliants met at Dow's headquarters in Midland, Mich., to discuss the contaminant's threat to consumers. "This material (dioxin) is exceptionally toxic; it has a tremendous potential for producing chloracne and systemic injury," Dow's chief toxicologist, V.K. Rowe, wrote to the other companies on 24 JUN 65. But none of the companies informed the military personnel charged with overseeing the defoliation contracts of the safety concerns until late 1967, according to depositions from the lawsuits. Internal documents from multiple companies indicate they were worried about the specter of tighter regulation. Only after a study for the National Institutes of Health showed that 2,4,5-T caused birth defects in laboratory animals did the military stop using Agent Orange, in 1970. Alan Oates, a Vietnam veteran who chairs the Agent Orange committee for Vietnam Veterans of America, said veterans have had little luck in their legal fight for compensation since the 1984 settlement. Veterans have argued unsuccessfully in court that the settlement was insufficient because it came too early for thousands of people whose illnesses did not develop until after all the settlement money had run out. One unresolved issue, Oates said, is whether chemical companies can be held liable for health costs associated with birth defects seen in the children of Vietnam veterans. "Now that it's starting to show it has an impact on future generations, what is the recourse for those folks?" Oates said. [Source: Chicago Tribune's Part 5 Agent Orange's lethal legacy 17 Dec 09 ++]

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VA Benefits Eligibility:

Eligibility for most veterans' health care benefits is based solely on active military service in the Army, Navy, Air Force, Marines, or Coast Guard (or Merchant Marines during WW II), and discharge under other than dishonorable conditions. Other groups may also be eligible for some health benefits. Returning service members, including Reservists and National Guard members who served on active duty in a theater of combat operations have special eligibility for hospital care, medical services, and nursing home care for five years following discharge from active duty. Active military service means full-time service, other than active duty for training, as a member of the Armed Services, or as a commissioned officer of the Public Health Service, Environmental Science Services Administration, National Oceanic and Atmospheric Administration, or its predecessor, the Coast and Geodetic Survey. Active duty for training for the National Guard and Reserve does not qualify as full-time service. There's no length of service requirement for former enlisted persons who started active duty before 8 SEP 80 or former officers who first entered active duty before 17 OCT 81. All other veterans must have 24 months of continuous active duty military service or meet one of the exceptions described below:

- A reservist who was called to Active Duty and who completed the term for which you were called, and who was granted an other than dishonorable discharge.
- A National Guard member who was called to Active Duty by federal executive order, and who completed the term for which you were called, and who was granted an other than dishonorable discharge.
- Request a benefit for or in connection with:
  a.) A service-connected condition or disability; or
  b.) Treatment and/or counseling of sexual trauma that occurred while on active military service; or
  c.) Treatment of conditions related to ionizing radiation; or
  d.) Head or neck cancer related to nose or throat radium treatment while in the military.
- Discharged or released from active duty for a hardship.
- Discharged with an "early out".
- Discharged or released from active duty for a disability that began in the service or got worse because of the service.
- Been determined by VA to have compensable service-connected conditions.
- Discharged for a reason other than disability, but you had a medical condition at the time that was disabling, and in the opinion of a doctor, would have justified a discharge for disability (in this last case, the disability must be documented in service records).

[Source: http://www4.va.gov/healtheligibility Dec 09 ++]

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VA Benefits Eligibility Update 01:

In addition to active military service veterans a number of groups who have provided military-related service to the United States have been granted VA benefits. For the service to qualify, the Secretary of Defense must certify that the group has provided active military service. Individuals must be issued a

discharge by the Secretary of Defense to qualify for VA benefits. Service in the following groups has been certified as active military service for benefits purposes:

- Women Air Force Service Pilots (WASPs).
- World War I Signal Corps Female Telephone Operators Unit.
- Engineer Field Clerks.
- Women's Army Auxiliary Corps (WAAC).
- Quartermaster Corps female clerical employees serving with the American Expeditionary Forces in World War I.
- Civilian employees of Pacific naval air bases who actively participated in defense of Wake Island during World War II.
- Reconstruction aides and dietitians in World War I.
- Male civilian ferry pilots.
- Wake Island defenders from Guam.
- Civilian personnel assigned to OSS secret intelligence.
- Guam Combat Patrol.
- Quartermaster Corps members of the Keswick crew on Corregidor during World War II.
- U.S. civilians who participated in the defense of Bataan.
- U.S. merchant seamen who served on blockships in support of Operation Mulberry in the World War II invasion of Normandy.
- American merchant marines in oceangoing service during World War II.
- Civilian Navy IFF radar technicians who served in combat areas of the Pacific during World War II.
- U.S. civilians of the American Field Service who served overseas in World War I.
- U.S. civilians of the American Field Service who served overseas under U.S. armies and U.S. army groups in World War II.
- U.S. civilian employees of American Airlines who served overseas in a contract with the Air Transport Command between 14 DEC 41 and 14 AUG 45..
- Civilian crewmen of U.S. Coast and Geodetic Survey vessels who served in areas of immediate military hazard while conducting cooperative operations with and for the U.S. Armed Forces between 7 DEC 41 and 15 AUG 45.
- Members of the American Volunteer Group (Flying Tigers) who served between 7 DEC 41 and 18 JUL 42.
- U.S. civilian flight crew and aviation ground support employees of United Air Lines who served overseas in a contract with Air Transport Command between 14 DEC 41 and 14 AUG 45.
- U.S. civilian flight crew and aviation ground support employees of Transcontinental and Western Air, Inc. (TWA), who served overseas in a contract with the Air Transport Command between 14 DEC 41 and 14 AUG 45.
- U.S. civilian flight crew and aviation ground support employees of Consolidated Vultee Aircraft Corp. (Consairway Division) who served overseas in a contract with Air Transport Command between 14 DEC 41 and 14 AUG 45.
- U.S. civilian flight crew and aviation ground support employees of Pan American World Airways and its subsidiaries and affiliates, who served overseas in a contract with the Air Transport Command and Naval Air Transport Service between 14 DEC 41 and 14 AUG 45.
- Honorably discharged members of the American Volunteer Guard, Eritrea Service Command, between June 21, 1942, and March 31, 1943.
- U.S. civilian flight crew and aviation ground support employees of Northwest Airlines who served overseas under the airline's contract with Air Transport Command from 14 DEC 41 to 14 AUG 45.
- U.S. civilian female employees of the U.S. Army Nurse Corps who served in the defense of Bataan and Corregidor during the period 2 JAN 42 to 3 Feb 45.

- U.S. flight crew and aviation ground support employees of Northeast Airlines Atlantic Division, who served overseas as a result of Northeast Airlines' contract with the Air Transport Command during the period 7 DEC 41 through 14 AUG 45.
- U.S. civilian flight crew and aviation ground support employees of Braniff Airways, who served overseas in the North Atlantic or under the jurisdiction of the North Atlantic Wing, Air Transport Command, as a result of a contract with the Air Transport Command during the period 26 FEB 42, through 14 AUG 45.
- Honorably discharged members of the Alaska Territorial Guard during World War II.

[Source: http://www4.va.gov/healtheligibility/eligibility/Others.asp Dec 09 ++]

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VA Home Loan Update 17:

VA offers a number of home loan services to eligible Veterans, some military personnel, and certain surviving spouses.

- **Guaranteed Loans:** VA can guarantee a portion of a loan made by a private lender to help you buy a home, a manufactured home, a lot for a manufactured home, a condominium unit, or a unit in a cooperative dwelling. VA also guarantees loans for building, repairing, and improving homes.
- **Refinancing Loans:** If you have a VA mortgage, VA can help you refinance your loan at a lower interest rate. You may also refinance a non-VA loan.
- **Special Grants:** Certain disabled Veterans and military personnel can receive grants to adapt or acquire housing suitable for their needs.
- **Time Limits:** There is no time limit for a VA home loan.

[Source: VA Pamphlet 21-00-1 JUL 09 ++]

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VA Prostate Radiation Treatment Update 03:

In a predecisional enforcement conference that was often pointed the Department of Veterans Affairs yesterday apologized repeatedly for a prostate-cancer program that gave incorrect radiation doses to veterans for six years at its main Philadelphia hospital. At the same time, officials from the Philadelphia VA Medical Center and the Veterans Health Administration mounted a vigorous defense against charges by the U.S. Nuclear Regulatory Commission that they had apparently violated eight regulations in the medical use of radioactive materials. VA officials also withdrew their own previous estimates of the number of patients who were affected, asserting that the mistakes were far less common than previously believed. NRC officials said they were surprised by the VA's about-face. After 19 months and numerous on-site inspections and delays, "now you come with a new criteria" for counting botched cases, said Steven A. Reynolds, director of nuclear-materials safety for NRC's Region III, which has led the agency's investigation. "It is troubling." The NRC demanded written testimony by 15 JAN to back up the VA's rationale to limit sanctions. The NRC also said it would issue violations and any penalties four to six weeks after that.

The four-hour hearing on 17 DEC was a chance for the VA to explain its troubled brachytherapy program. Between FEB 02 and JUN 08, a VA team gave incorrect radiation doses to 97 of 114 veterans implanted with tiny radioactive seeds to destroy their cancer. That was the official count the VA gave up until yesterday. Using new assessment criteria developed by a "blue-ribbon panel" of medical experts - and not yet approved for use by the VA - the agency's top radiation oncologist said that in fact 19 veterans, not 97, had gotten incorrect doses of radiation to their prostate or surrounding tissue. The VA's original standard estimated the radiation dose delivered to the prostate. The agency's new methodology is to examine where the seeds are placed in and around the prostate. The new criteria are less subjective, said Michael Hagan, the VA's national director of radiation oncology. They are not meant to "mitigate" the problems of the Philadelphia program, which included no quality assurance or independent oversight, he said. Even by the new standard, about one in five veterans treated with brachytherapy got substandard care at the Philadelphia VA. "In my opinion, these results reflect a program that had substantial problems, but not at the level characterized," Hagan said. Before Hagan's introduction of a new analysis of the treatments yesterday, the VA's own analysis of the implants found that 63 were underdosed and that 35 got too much radiation to tissue near their prostates.

So far, 11 of the 114 men have had a recurrence of prostate cancer, a rate that is within the expected range for brachytherapy treatments, the VA officials told the NRC. An additional eight men have shown signs of a possible return of the cancer, and Hagan said he would not be surprised if the number of those whose cancer returns rises in the next few years. Prostate brachytherapy involves implanting dozens of tiny radioactive seeds into the acorn-size gland to kill cancerous cells over several months. It is an effective treatment when done correctly. Records show that the Philadelphia VA's program was deeply flawed from its earliest patients, and that doctors and officials repeatedly missed chances to correct it. So far, 31 veterans or wives have filed claims totaling $58 million against the VA. The mistakes led to internal investigations, congressional scrutiny, the NRC probe, and one by the VA's inspector general. So far one physician has accepted a three-day suspension. A radiation safety official received a letter of reprimand. Several lawmakers who have investigated the cases said that the VA responses were weak and that the agency acted only after prominent newspaper articles appeared in the summer, detailing radiation overdoses and underdoses. Last month, the NRC cited the VA for eight apparent violations, including the failure to train doctors and other staff on how to identify bad implants, lacking procedures to ensure safe implants and not reporting mishaps as quickly or fully as required. [Source: Philadelphia Inquirer Josh Goldstein article 18 Dec 09 ++]

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VA Outside Medical Claims:

Occasionally veterans go to or are transported to non-VA civilian health care facilities for "emergent" treatment of their particular medical condition. To obtain VA payment for this care certain procedures

must be followed to file a claim for payment for these services. Beginning with dates of service on and after 1 MAR 09 you must submit claims for VA payment consideration for emergency care not previously authorized to: Department of Veterans Affairs, Financial Services Center (FSC), Non-VA Emergency Claims, P.O. Box 149364, Austin, TX 78714-9364. All claims with dates of service before 1 MAR 09 must be mailed to your local VA Medical Center. To expedite claims processing, be sure that each claim is complete and filed within 90 days following the episode of care. Incomplete claims will be returned. Do not forget to include documentation of any communication with the VA regarding patient treatment or disposition. A call center at FSC is available to assist you with payment and claims processing inquiries. You may contact the customer call center at 1(866) 372-1144, M-F 08-1630 (CST) excluding Federal holidays. A claim file is complete if it has the following documentation:

a. Complete UB-04 or CMS-1500 claim form to include the National Provider Identification (NPI) number

b. Supporting medical documentation for the following services is needed for claims adjudication:

- **Inpatient:** Admission sheet, discharge summary, operation reports, daily progress notes, and doctor orders.
- **Outpatient:** Emergency room treatment notes (including chief complaint, and examination/evaluation results), applicable observation notes, any consultation reports, and diagnostic findings.

- **Emergency Transportation:** Transportation notes indicating location the episode of emergency care took place and facility and address the patient was transported to. The transportation notes should include the chief complaint, examination/evaluation results, applicable observation notes, and any diagnostic findings

[Source: California VFW VSO msg. 18 Dec 09 ++]

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Traumatic Brain Injury Update 10:

On 16 DEC a briefing was held by former Secretary of the Army Martin Hoffman in Hyperbaric Oxygen Therapy in the treatment of brain injuries. During the presentation, Sec. Hoffman highlighted the need for additional funding and research into the treatment of the numerous traumatic brain injuries (TBI) from Iraq and Afghanistan by Hyperbaric Oxygen Therapy (HBOT 1.5). The 1.5 in the acronym represents the treatment atmospheric pressure of 1.5 atmospheres. Hyperbaric Oxygen Therapy is a well-tested option in treating at least 13 other medical conditions. A very small sample of around 30 Iraq/Afghanistan casualties have been very successfully treated using this method. Additionally there are other civilian studies that support this treatment method. On 12 JUL, the House of Representatives unanimously passed legislation authored by Congressman Pete Sessions (TX-32) to recognize and report the results and planned expansion of Hyperbaric Oxygen Therapy in Veterans Affairs medical facilities. As an amendment to the Fiscal Year 2010 Military Construction and Veterans Affairs Appropriations Act (H.R.3082), Sessions' legislation requires the VA to submit a report to Congress detailing the current and planned use of the Hyperbaric Oxygen Therapy in VA medical facilities, including the number of veterans and types of conditions being treated with HBOT, their respective success rates, and the current inventory

of hyperbaric chambers. Over a year ago DoD announced a clinical trial for HBOT 1.5, but no progress has been made due to lack of resources to design the test and begin testing patients. If the preliminary results of a very tiny test can be duplicated for the larger number of wounded warriors who have been diagnosed with TBI, this needs to be proven as soon as possible in order that our troops can be given the very best treatment. [Source: NAUS Weekly Update 18 Dec 09 ++]

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VA Tinnitus Care Update 01:

A University of Alabama researcher is embarking on a $5.6 million phase-three, randomized, controlled clinical trial to evaluate the effectiveness of an innovative treatment that uses a noise-generating device, along with counseling, to alleviate the debilitating effects of tinnitus - that ringing in the ears that drives some people to distraction. The non-medical habituation-based treatment being studied is known as Tinnitus Retraining Therapy or TRT. The investigational study of TRT will involve tinnitus sufferers drawn from the U.S. Navy, Marines and Air Force, and will be conducted in Navy and Air Force flagship hospitals in California, Texas, Maryland and Virginia. Researchers expect to recruit 228 participants for the study. Dr. Craig Formby, UA distinguished graduate research professor in the department of communicative disorders, leads the NIH-sponsored study. Formby's team at UA leads the clinical part of the study, which is funded by a $3.2 million award from the National Institute of Deafness and Other Communication Disorders. Researchers at Johns Hopkins University have received a $2.4 million award to manage and analyze the study data. The project will be spread over five years, including four years for recruiting study participants and conducting the treatment and follow-up measurements.

Tinnitus is the No. 1 service-connected disability among veterans returning from the Middle East conflicts. In 2008, compensation for tinnitus disability in the VA medical system alone exceeded $500 million and is projected to exceed $1.1 billion and affect more that 800,000 veterans by 2011. "Tinnitus is a noise inside the ear or head in the absence of any sound that could account for it," Formby says. "We don't know wht happens. In some cases, it's related to an acoustic insult or gunfire. However, there may be no obvious cause for the tinnitus for many sufferers. It's some sort of over-stimulation of the auditory system that produces hyperactivity either at a peripheral or central level." Most people who have tinnitus ignore it, Formby says, but for some it's torture. As many as 50 million Americans experience tinnitus. Estimates are that for about 2 to 5 million people, the problem is incapacitating. "We know of reports of sufferers who have chronic debilitating tinnitus that is so troublesome that they would elect to cut the auditory nerve to get rid of the persistent ringing," Formby says. The current standard of care involves counseling people with debilitating tinnitus. The counselors typically try to help the tinnitus sufferer to manage the problem by suggesting coping strategies and by providing information about tinnitus. "The standard of care historically has included reassurance that the patient's condition is not life threatening nor an indicator of imminent hearing loss," he says.

Formby will compare the current standard of care for management of tinnitus in the military with TRT and with a placebo condition that will control for the treatment effects of the noise-generator component of the TRT treatment. After specialized TRT counseling to start the habituation process, each of the affected military personnel will use a pair of ear-worn noise-generator devices produced by General Hearing Instruments that produce a "soft seashell-like noise," which blends with the tinnitus. "In TRT theory, the soft noise throughout the day from the noise generators helps to facilitate the habituation process, which is initiated by the counseling," Formby says. "Patients are encouraged to use their devices from the time they start their day until the end of the day or at least for eight hours a day. The patients are told to forget the devices are on. Don't worry about the tinnitus, don't keep a log, and don't worry about how bad their tinnitus is from hour to hour or day to day; just go on with their lives." They are also taught about their auditory system and how it is believed to work together with parts of the brain and central nervous system to give rise to their debilitating tinnitus conditions."

In the clinical trial, Formby and his co-researchers will measure treatment-related changes in the impact of the tinnitus on each participant's daily activities. They also will track measures of perception, awareness, and annoyance of the tinnitus for each participant in the study. The questionnaire responses for participants who are assigned to the TRT treatment group will be compared with the responses of tinnitus patients given the current standard-of- care treatment for tinnitus in the military and with a third treatment group who are assigned to the placebo noise-generator control. "If successful, then most patients receiving the full TRT treatment will likely report the tinnitus is no longer troublesome for them at the conclusion of the study," Formby says. "If you make a measurement of the tinnitus in terms of its pitch and loudness characteristics at the start of the study and at the end of the study, then the perceived tinnitus properties will likely be similar. But the patient's perception of the annoyance and awareness of the tinnitus will be reduced, and the tinnitus will not be bothersome to them in the way it was at the start of the study. The other treatment groups are not expected to benefit appreciably from their interventions."

Formby has been working with the U.S. military since 1999, to develop the study protocol for this pioneering investigation, which is the first definitive phase-three clinical trial of TRT sponsored by NIH. The clinical trial will take place at the Naval Hospital Camp Pendleton in Irvine, Calif.; the National Naval Medical Center in Bethesda, Md.; the Portsmouth Naval Hospital in Portsmouth, Va.; the San Diego Naval Hospital; the David Grant Medical Center at Travis Air Force Base in Fairfield, Calif.; and the Wilford Hall Medical Center at Lackland Air Force Base in San Antonio, Texas. The department of communicative disorders is part of UA' s College of Arts and Sciences, the University's largest division and the largest liberal arts college in the state. Students from the College have won numerous national awards including Rhodes Scholarships, Goldwater Scholarships and memberships on the USA Today Academic All American Team. [Source: University of Alabama Press Release 16 Dec 09 ++]

GI Bill Update 65:

VETERANS NEWS & VIEWS – JANUARY, 2010

The DoD released the 2010 Basic Allowance for Housing charts on 15 DEC. This is potentially big news for veterans using the Post-9/11 GI Bill because the living stipend (aka housing stipend) is directly tied to the BAH for an e-5 with dependents. Although some may see their GI Bill Living stipend increase by as much as 13.6% in 2010, the average increase will be more like 2.5%. Some may see no increase at all because the rates for 43% of the military housing areas covered by BAH will actually drop in 2010. The first question is, when will this new BAH rate go into effect for the GI Bill? Will it be increased in January or will they wait until July and increase it with the annual tuition and fee rate adjustment? Also, what will the VA do in cases where the local BAH has dropped? The DoD has a grandfathering policy (individual rate protection) that prevents the decrease of a BAH rate as long as the status of a servicemember remains unchanged. In the case of a veteran student this should mean that a current student will not see a decrease in their living stipend. Only new students or those changing their status would see the lower rate. As always, it seems there are more questions with the Post-9/11 GI Bill then there are answers. [Source: Military.com Terry Howell article 16 Dec 09 ++]

VA Hospital Report Card:

For the second consecutive year, the Department of Veterans Affairs (VA) has released a "hospital report card" as part of VA's effort to provide the public with a transparent accounting of the quality and safety of its care. In addition, for the first time, data from both the 2008 and 2009 reports will be available to the public in machine-readable format on www.Data.gov. To empower Veterans and the public at large to track quality, safety and access to Veterans Health Administration (VHA) facilities, VA's hospital report cards include raw data on care provided in outpatient and hospital settings, quality of care within given patient populations, and patient satisfaction and outcomes. VA issued its first facility-level report on quality and safety in MAY 08. As part of the Obama Administration's commitment to open government and accountability, VA highlights its rigorous quality programs and actions taken to address the issues VA identified from the last report.

The report gives the health care system high marks, with VA facilities often outscoring private-sector health plans in standards commonly accepted by the health care industry. "Patient-centric care is our mission," said Shinseki. "As Secretary, I am committed to continuing to meet and surpass our high standards of care each and every day. In addition to allowing VA to demonstrate the quality and safety of its care, the report card provides opportunities to enhance health services ... it will become a valuable resource of information for Veterans, stakeholders and the department ... It will allow VA's health care system to be forward looking and focused on advancement." The 2009 report card highlighted:

- Marked improvements in smoking cessation counseling provided to 89% of Veteran patients, a 6% improvement from 2008 and among all ages at risk, 94% of Veterans received a pneumonia immunization, a 4% improvement.

- There is more to be done for women Veterans. To address this priority and provide women Veterans with the highest quality care VA has implemented several initiatives, such as placement of women advocates in every outpatient clinic and medical center, and creating a "mini-residency" program on women's health for primary care physicians.
- Minority Veterans are generally less satisfied with inpatient and outpatient care than other Veterans. In addition to targeting outreach efforts to these Veterans, a minority Veteran program coordinator has been placed in every medical center.

[Source: VA Press Release 9 Dec 09 ++]

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VA SAH Update 06:

Rep. Stephanie Herseth Sandlin (D-SD), chairwoman of the House Veterans' Affairs subcommittee on economic opportunity, recently conducted a hearing to review the Department of Veterans Affairs' special adapted housing (SAH) grants programs. Veterans or service members who have specific service-connected disabilities may be entitled to a VA grant for the purpose of constructing an adapted home or modifying an existing home to meet their adaptive needs. The goal of these programs is to provide a barrier-free living environment that affords the veterans or service members a level of independent living that they may not normally enjoy. The hearing specifically addressed the flexibility and sufficiency of the existing grants to address the current needs of veterans. "According to the Defense Manpower Data Center at the Department of Defense, approximately 35,000 service members have been wounded in Iraq and Afghanistan," said Sandlin. "Today, we will receive timely testimony that foreshadows the increased need for adaptive housing grants. In caring for our injured men and women in uniform, we must continue to address their needs so they may live as independently as possible after their honorable military service." Three types of grants are administered by VA to assist severely disabled veterans in their adaptive housing needs.

- Specially Adapted Housing Grant generally used to create a wheelchair-accessible home.
- Special Home Adaptations Grant generally used to assist veterans with mobility throughout their homes.
- Temporary Residence Adaptation Grant available to eligible veterans temporarily residing in a home owned by a family member.

Thomas Zampieri of the Blinded Veterans Association (BVA) provided testimony about the need for sufficient adaptive housing grants for veterans. He said it is "important that adaptive housing basic grant adjustments keep pace with residential home cost-of-construction index for each preceding year for labor and construction materials." If disabled veterans are not able to make adaptive changes to their homes, they run the risk of falls and injuries that result in expensive emergency-room visits and costly hospital admissions. Further, if accessible housing grants are not sufficient to allow disabled veterans to live independently at home, the alternative high cost of institutional care in nursing homes will occur, he said. Mr. Zampieri also reported that current blindness standards are overly restrictive, hurting "functionally blinded" veterans from the Iraq and Afghan wars and some veterans with visual impairments caused by

traumatic brain injuries requiring assistance and adaptive technology "because they would never qualify for this current 5/200 standard leaving them with no grants."

Mark Bologna, director of Loan Guarantee Services at VA, discussed recent improvements: "Congress changed the program from a one-time to a three-time use program. This change has allowed individuals to make additional adaptations to their homes or upgrade existing adaptations. If they move to other homes and have remaining eligibility, they may now use the program to adapt the new homes as well. These legislative changes have significantly improved the benefits available to severely injured veterans and service members and have increased the overall flexibility of the SAH Grants program. Rep. Bob Filner (D-CA), chairman of the House Committee on Veterans' Affairs noted, "Every year, we have a new pool of veterans returning from the combat zones with serious injuries that include losing a limb, loss of vision, or suffering from traumatic brain injury. Now, more than ever, VA needs to actively advocate and provide support for wounded veterans, and the adaptive housing grant program is absolutely instrumental in the reintegration efforts of these heroes." [Source: Washington Times Sgt. Shaft article 17 Dec 09 ++]

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VA Contractor Use Update 01:

Lawmakers are considering legislation to shape up what one called "major deficiencies" in Veterans Affairs Department contracting, in the wake of critical watchdog reports. In October, the Government Accountability Office released a report showing the service-disabled, veteran-owned small business contracting program was vulnerable to fraud and abuse. By conducting 10 case studies, the watchdog agency found $100 million in contracts earned through fraud or abuse of the program. GAO reviewed the results of that study for the House Veterans' Affairs Subcommittee on Oversight and Investigations during a hearing on 16 DEC. The subcommittee also heard from several veteran-owned companies, which lamented everything from significant contract delays to a lack of communication between the agency and vendors. "It is no secret that there are major deficiencies within VA's procurement process, and to blame are a number of things, including a lack of a centralized acquisition structure, self-policing policies in place that allow fraud and abuse, and continuous material weaknesses," said Rep. Harry Mitchell (D-AZ), chairman of the subcommittee. Mitchell said he is optimistic that reform of the system can be accomplished, but added that policy and procedural changes might be necessary.

Rep. Steve Buyer (R-IN), ranking member of the full Veterans' Affairs Committee, on 8 DEC introduced a potential legislative fix. According to Buyer, the 2009 Department of Veterans Affairs Acquisition Improvement Act (H.R.4221) would "completely restructure VA's procurement contracting system in an effort to increase the efficiency and effectiveness of the overall acquisition process." The bill would establish an Office of the Assistant Secretary for Acquisition, Construction and Asset Management, and charge this unit with setting procurement policy and structuring the acquisition bureaucracy appropriately. The office also would be responsible for overseeing contracts and maintaining

a verifiable database of service-disabled veteran-owned small businesses. "It is clear that VA requires a centralized system that provides strict oversight and direction for its acquisition processes," Buyer said. "The bill ... would implement a streamlined process that allows for greater efficiency and better enforcement of policies and regulations intended to increase contracting opportunities for disabled veteran entrepreneurs."

Glenn Haggstrom, executive director of the VA Office of Acquisition, Logistics, and Construction and acting chief acquisition officer, told the subcommittee the department is making significant strides centralizing and improving its procurement processes. He touted the realignment of the Veterans Health Administration under a central structure with four regional offices focused on internal business processes, as well as training and oversight. The department also is working to improve relationships with contractors. Haggstrom said VA recently established a Supplier Transformation Relationship Initiative. "For the first time ever, VA's supplier community is being treated as a critical component to VA's success," Haggstrom said. "This initiative improves VA's acquisition process by establishing better and more transparent communications with vendors, which increases VA's access to industry's best practices and innovation." [Source: GOVExec.com Elizabeth Newell article 16 Dec 09 ++]

Tricare Retired Reserve:

A new program will offer "gray area" reservists the opportunity to purchase Tricare health care coverage. While qualified members of the Selected Reserve may purchase premium-based coverage under Tricare Reserve Select (TRS), retired National Guard and Reserve personnel did not have Tricare health coverage options until they reached age 60. Under a provision of the National Defense Authorization Act for 2010, that's all changed. The new provision will allow certain members of the Retired Reserve who are not yet age 60 "gray-area retirees), to purchase Tricare Standard (and Extra) coverage. Tricare Extra simply means beneficiaries have lower out of pocket costs if they use a network provider. "We're working hard to coordinate all the details of eligibility, coverage and costs, and expedite implementation of this important program," said Rear Adm. Christine Hunter, deputy director of the Tricare Management Activity. "This is a major benefit program with implementation on the same magnitude as TRS. It will require detailed design, development and testing, but qualified retired reservists should be able to purchase coverage by late summer or early fall of 2010."

While the health care benefit provided for gray-area retirees will be Tricare Standard and Extra – similar to TRS – the new program will differ from TRS in its qualifications, premiums, copayment rates and catastrophic cap requirements. The program is tentatively called Tricare Retired Reserve. The new statute requires premium rates to equal the full cost of the coverage. That is the major difference contrasted with TRS, where the statute provides that Selected Reserve members pay only 28 percent of the cost of the coverage. Premiums for the new gray area retiree program will be announced after program

rules are published in the Federal Register. This new program offers an important health coverage option for Reserve and National Guard members who served their country honorably before hanging up their uniforms at retirement, said Hunter. For more information about Tricare benefits go to http://www.tricare.mil. [Source: Tricare No. 09-76 17 News Release Dec 09 ++]

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Offers of Help

VA Benefits Assistance:

If you need help learning about VA programs or with a VA application process, recommend you work with an approved Veterans Service Organization (VSO). It's their job to help you at no cost. To find a VSO go to VA's Directory of Veterans Service Organizations at http://www1.va.gov/vso/index.cfm. You can also check with your state VA department and your state's network of county veteran service officers. Most are listed at www.va.gov/statedva.htm. If someone approaches you to help with a VA application, claim, or appeal, check to see if they are a VSO. Chances are they won't be because VSOs don't solicit for your business, you have to find them. There are a few organizations which use the front of helping with VA benefits as a way to meet prospective customers. These groups solicit for your business. They offer to get you money from the VA for long term care cost, assisted living, or survivor benefits. Tread lightly around these offers. On the surface, they appear legitimate but if not, it could wind up costing you time and money in the long run. Some things to look for are:

- Organizations having at their base, a financial services firm.
- Organization that are not an official Veteran Service Organization (VSO). VSOs are chartered by the VA to act as an official VA representative for members on VA matters.
- Organizations wanting to help in an area that is not their core business.
- Inability to get a satisfactory answer about how they make their money.
- The motive behind a financial service firm's interest in helping you with issues that get them nothing in return. The process, bureaucracy and time involved in helping vets with VA programs is substantial. Also, helping with some VA programs provides access to a veteran's complete financial information.

[Source: MOAA Financial Frontlines Shane Ostrom article 9 Dec 09 ++]

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Veterans' Court Update 04:

In hopes of helping veterans suffering from mental illness and substance abuse, Texas Travis County authorities are looking at creating a special veterans court docket, which would channel those charged with certain crimes into treatment and social services rather than incarceration. A handful of such courts have been created across the country since 2008, as officials respond to growing numbers of veterans returning from wars in Iraq and Afghanistan. As many as 30% are thought to suffer from illnesses ranging from post-traumatic stress disorder and traumatic brain injury to major depression. Too many, officials

say, turn to alcohol and drugs to self-medicate, often leading to entanglements with the criminal justice system. Last month, Harris County set up a veterans court pilot project, and Tarrant County last week decided to accept a $200,000 grant from Gov. Rick Perry's office to hire staffers to manage a veterans court there. The Texas Legislature passed a law this year allowing counties to create veterans courts. Travis County officials say not enough is being done locally to identify veterans in need of mental health treatment.

The possible creation of a local veteran's court was hailed by veterans groups as a vital step. "Treatment is far more effective and far less expensive," said Paul Sullivan, head of the Austin-based group Veterans for Common Sense. Travis County Attorney David Escamilla said a team of prosecutors, defense lawyers and judges will need to work out several details before a veterans court becomes reality, including determining which offenses would be eligible and what services would be offered. Officials will also need to identify funding for the court. "But there's a great deal of momentum to move forward with this," Escamilla said, adding that the court would probably begin handling misdemeanor cases but could take on felony cases. He said the court would be modeled on the county's mental health court, which handles offenders suffering from mental health problems in hopes of preventing repeat offenses. The nation's first veterans court began in January 2008 in Buffalo, N.Y., where veterans are typically ordered to undergo counseling, find work and stop using drugs or alcohol instead of being sentenced to jail or prison time.

The court isn't the only program local officials hope will reach veterans. This month, Travis County embarked on a six-month pilot program that requires veteran offenders to get evaluated and treated by the Department of Veterans Affairs as part of their pretrial release from jail. The efforts stem from a two-year Travis County program called the Veterans Intervention Project, which on 14 DEC released the results of a 90-day study of veterans booked into the Travis County Jail. The study, which relied on self-reporting through questionnaires, found that about 150 veterans were booked into the Travis County Jail each month, or 3.4% of total bookings. Of those, 18% served in Iraq or Afghanistan, 13% in Vietnam and 54% in noncombat zones. Most charges (73%) were for misdemeanor crimes, with driving while intoxicated, assault and drug possession the most frequent charges. Of the felony charges, aggravated sexual assault, aggravated kidnapping and delivery of a controlled substance were the top ones. About one-third of the veterans were arrested two or more times during the 90-day study, highlighting the need for early intervention, officials said.

The jail study found that few locked-up veterans were accessing help through the VA, which offers services for mental health issues and substance abuse. While 86% of the arrested veterans were eligible for such services, just 35% had received them. Officials said the reasons the veterans did not seek help include the stigma within the military attached to seeking mental health help and other-than-honorable discharges, in which veterans are not allowed access to VA services. Some veterans advocates point to a vicious cycle in which active-duty service members suffering from post-traumatic stress and other maladies turn to drugs to self-medicate, which can lead to a dishonorable discharge and inability to access

needed mental health help. Maj. Darren Long, who represents the Travis County sheriff's office on the veterans' task force, said there needs to be more understanding of the issues facing veterans, especially those fresh from combat tours. "We come across them when they are in a mental health crisis," he said. "We owe it to them. They take care of us and our freedoms. Now it's our turn to take care of them when they come back home." [Source: American-Statesman Jeremy Schwartz article 15 DEC 09 ++]

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Agent Orange Guam Update 01:

GUAM may be included in a congressional bill that expands the compensation program for veterans who were exposed to Agent Orange and other types of defoliants used by American troops during Vietnam War. H.R.2254, titled "The Agent Orange Equity Act of 2009," has received a bipartisan support in the House of Representatives, with over 200 congressmen having signed up as cosponsors. "Republicans and Democrats alike have joined together to stand up for Agent Orange veterans," said Rep. Bob Filner (D-CA) author of H.R.2254, and chairman of the House Veterans' Affairs Committee. In a press statement released in late NOV, Filner said his bill would expand the eligibility for presumptive conditions to all combat veterans of the Vietnam War "regardless of where they served." The current compensation program for Agent Orange exposure covers only those who were deployed to Vietnam. Filner issued the statement on the heels of a recent ruling by the Department of Veterans Affairs' Board of Appeals in Texas, which rejected the benefit claims sought by a veteran who was stationed at Andersen Air Force Base during the Vietnam War. Despite personal testimonies and photos of herbicide barrels sent via mass email by veterans who claimed to have handled Agent Orange at AAFB, the U.S. Department of Defense has not officially acknowledged that Agent Orange and other rainbow herbicides were ever used on Guam.

While acknowledging the statements made by the claimant, the appeals board said the claims were not supported by official evidence. "The veteran's record personnel records indicate that he served in Guam during the war in Vietnam," the appeals board stated in its JUN 09 ruling. "However, the Department of Defense has not established that Agent Orange was used in Guam during the period of the veteran's service." The most recent ruling, however, was inconsistent with four previous decisions that confirmed the use of Agent Orange on Guam between early 1960s and late 1970s. These four previous decisions were based on the 2004 Dow Chemical Risk Report. With no legal support to back them up and no immediate relief on the horizon, veterans who were deployed to Guam have created an online network and sending mass email to demand U.S. lawmakers' attention to their plight. Filner, meanwhile, acknowledges that while Current law requires the Department Veterans Affairs to provide care for service members exposed to Agent Orange by virtue of their 'boots on the ground,' it "ignores veterans that served in the blue waters and the blue skies of Vietnam. Time is running out for these Vietnam veterans. Many are dying from their Agent Orange related diseases, uncompensated for their sacrifice," Filner said in a press statement. "There is still a chance for America to meet its obligations to these estimated

800,000 noble veterans. The courts have turned their backs on our veterans, but I believe this Congress will not allow veterans to be cheated of their earned benefits," he added. [Source: Marianas Variety News & Views Mar-Vic Cagurangan article 30 Nov 09 ++]

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PTSD Update 35:

Many soldiers, lawyers and mental health workers say that the rules governing confidentiality of psychotherapist-patient relations in the military are porous. The rules breed suspicion among troops toward therapists, those people say, reducing the effectiveness of treatment and complicating the Pentagon's efforts to encourage personnel to seek care. The problem with the military rules, experts say, is that they do not safeguard the confidentiality of mental health communications and records as strongly as federal rules of evidence for civilians. Both systems say therapists should report patients when they seem a threat to themselves or to others. But the military rules include additional exceptions that could be applied to a wide range of suspected infractions, experts say. "There really is no confidentiality," said Kaye Baron, a psychologist in Colorado Springs who has been treating soldiers from Fort Carson and their families for eight years. "You can find an exception to confidentiality in pretty much anything one would discuss."

The issue has gained new attention with the recent mass shootings at Fort Hood that killed 13 and wounded 43. In the weeks before the rampage, the accused gunman, Maj. Nidal M. Hassan, an Army psychiatrist, told colleagues and Army lawyers that he wanted to report soldiers who had admitted in counseling sessions that they witnessed or committed war crimes in Iraq or Afghanistan. War crimes can include acts like torture, murder, sexual assault and cruel treatment. Though Major Hasan was discouraged from filing reports on his patients, military officials say, he would have been within his rights as an Army psychiatrist to have done so. Major Hasan's efforts to report war crimes were first reported by ABC News. Pentagon officials acknowledge that the psychotherapy-patient privilege in the military is not absolute. But they assert that the exemptions are relatively narrow. Those rules apply to both civilian and military mental health professionals who deal with military personnel. Cynthia L. Vaughan, a spokeswoman for the Army medical command, said the rules were intended mainly to protect military personnel, installations and operations, or to prevent child or spousal abuse. In those situations, she said, therapists have a duty to report patients to commanders without their patients' consent. But they do not have a duty to report other kinds of crimes, she said.

The waiver that soldiers are asked to sign is simply to notify them that "there are circumstances when disclosure of behavioral health information can occur without prior consent," Ms. Vaughan said. "We strongly encourage soldiers to seek behavioral health treatment," she added. Psychotherapists are not required to report possible war crimes, Ms. Vaughan said. But it is considered a "general duty" under

Defense Department directives to do so. Ms. Vaughan said the Army could not comment on whether Major Hasan, whose job was to interview Fort Hood soldiers who were being medically discharged, actually filed reports on his patients. She added that "in normal day-to-day operations, the Army will investigate any report of a possible war crime by whatever means it is made known." Some legal and mental health experts say the military's rules on psychotherapist-patient privilege are not clear-cut. Michelle Lindo McCluer, a former Air Force lawyer who is the executive director of the National Institute of Military Justice, said that some exceptions to the privilege are so broadly worded that "you could drive a truck through them."

One exception in the military rules states that confidentiality can be breached without a patient's consent when "federal law, state law or service regulation imposes a duty to report information." Another says privilege can be broken to ensure the safety of military personnel and "the accomplishment of a military mission." The phrase "military mission," Ms. McCluer said, could entail almost anything a unit does. Ms. McCluer said that when she was a defense lawyer for the Air Force from 2000 to 2003, she advised clients to seek mental health counseling from chaplains because the privilege rules on their communications are stronger than for therapists. Until about 10 years ago, there was no psychotherapist-patient privilege in the military, meaning that any communication between a therapist and service member could be reviewed by prosecutors or commanding officers without the consent of the patient. The qualified privilege was created in 1999 to bring military rules more in line with the 1996 Supreme Court ruling in Jaffee v. Redmond that said federal courts must allow psychotherapists and other mental health professionals to refuse to disclose patient records in judicial proceedings. In the years since the limited privilege was established, there has been little litigation testing its bounds, lawyers say. There has also been little written guidance for therapists, experts say.

Without bright-line rules, many troops say they are concerned that their therapists will reveal not just admissions of major crimes but also minor infractions that might hurt their military careers or prevent them from being returned to combat duties. "I personally have learned to be very vague about what I say," said a 16-year Army veteran at Fort Carson who is in the process of receiving a medical discharge and did not want to be identified because he was concerned that speaking out about his experience would jeopardize his case. Shannon P. Meehan, a former Army captain and tank platoon leader who was recently medically discharged from the Army, said his candid conversations with a psychiatrist at Fort Hood helped him cope with post-traumatic stress disorder. He had felt deep guilt about an order he gave in Iraq for a missile strike that killed women and children. That 2007 event became a central chapter in a book he has written with one of his former English professors, "Beyond Duty." Mr. Meehan said that the strike was clearly within the rules of engagement. But other soldiers might not be so certain about their actions during the chaos of combat, and he said he worried that troops who thought their therapists might report them would not discuss their deepest secrets — secrets that may be at the root of personal anguish or mental problems. [Source: New York Times Kames Dao/Dan Frosch article 6 Dec 09 ++]

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Breast Cancer Update 02:

Some women with very advanced breast cancer may have a new treatment option. Doctors report a combination of two drugs that more precisely target tumors significantly extended the lives of women who had stopped responding to other medicines. It was the first big test of combining Herceptin and Tykerb. In a study of 300 patients, women receiving both drugs lived nearly five months longer than those given Tykerb alone. Doctors hope for an even bigger benefit in women with less advanced disease, and were elated at this much improvement for very sick women who were facing certain death. "We don't see a lot that works in patients who have seen six prior therapies as they did in this trial, so that alone is exciting," says Jennifer Litton, a breast cancer specialist at the Univ. of Texas M. D. Anderson Cancer Center. The good results are in stark contrast to two other studies that found no survival advantage from Avastin, a $30,000-a-month drug whose approval for breast cancer patients was very controversial. Considering Avastin's potential side effects—blood clots in the lungs, poor wound healing, kidney problems—a survival benefit "would have made the cost of the drug less painful to take," Litton says. She had no role in any of the studies, which were reported 11 DEC at the San Antonio Breast Cancer Symposium sponsored by the American Association for Cancer Research, Baylor College of Medicine and the UT Health Science Center.

Herceptin and Tykerb aim at a protein called HER-2 that is made in abnormally large quantities in about one-fourth of all breast cancers. Herceptin blocks the protein on the cell's surface; Tykerb does it inside the cell. "It's kind of like having a double brake on your tumor. If the first one fails, the second one does the job," says Kimberly Blackwell of Duke Univ. She led the combo treatment study and has consulted for its sponsor, British-based GlaxoSmithKline PLC, which makes Tykerb, and for Genentech, which makes Herceptin and Avastin. Women in the study had already received Herceptin alone or with various chemotherapy drugs and still were getting worse. They were randomly assigned to receive only Tykerb or both drugs, to see whether the combo might help Herceptin regain its effectiveness. Median survival was analyzed after about 75% of the women had died — roughly two years after the study began. It was 61 weeks in the combo group versus 41 for those taking only Tykerb. That likely underestimates the combo's true benefit because women on Tykerb alone were allowed to add Herceptin partway through the study if they continued to worsen, and many of them did, Blackwell says. One woman on the combo in the study suffered a fatal blood clot. The only other common, serious side effect was diarrhea, which plagued 7 to 8% of each group. Herceptin costs about $10,000 a month; Tykerb, $5,000 to $6,000.

Eric Winer, breast cancer chief at the Dana-Farber Cancer Center in Boston, says several studies now show that Herceptin still helps women even when their cancers seem to be getting worse. "Herceptin is like a big roadblock on a superhighway. Eventually the cancer finds a way around it by taking an off ramp. But it's much less efficient to take that off ramp, so Herceptin is still having some influence on that cancer," says Winer, who, like Litton, has no financial ties to any drugmakers. "Herceptin is a drug that keeps on giving," he says. Not so for Avastin, which works by crimping a tumor's blood supply. The

federal Food and Drug Administration approved its use in women whose cancers had spread beyond the breast over the objections of FDA advisers who wanted more evidence of benefit for these patients. Now, two big international studies show that Avastin modestly delayed the time breast cancer took to worsen, but had no effect on overall survival. Avastin also is approved to treat certain lung, brain and colon cancers, and the new studies that follow have no bearing on its use in those patients:

- A 684-patient study of Avastin with chemotherapy as a second-try treatment for women whose cancers do not respond to Herceptin.
- A 736-patient study of Avastin plus Taxotere or a dummy drug as first-time treatment for cancers that had recurred or spread beyond the breast.

[Source: Lab News Daily AP article 14 Dec 09 ++]